Syracuse Pediatrics Registration Form

Patient Information

DATE _____

Name _____ Date of Birth _____

Soc. Sec. # _____ Male or Female

Address _____ City/State/Zip _____

Home Phone _____ Cell/Other phone _____

Email _____

Mother's Information

Name _____ Date of Birth _____

Maiden Name _____ Soc. Sec. # _____

Address _____ City/State/Zip _____

Home Phone _____ Cell/Other phone _____

Email _____

Employer _____ Work Phone _____

Position _____

Employer Address _____

Father's Information

Name _____ Date of Birth _____

Soc. Sec. # _____

Address _____ City/State/Zip _____

Home Phone _____ Cell/Other phone _____

Email _____

Employer _____ Work Phone _____

Position _____

Employer Address _____

Insurance Information

Primary Insurance Company Name _____

Policy ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

Relationship to patient _____

Secondary Insurance Company Name _____

Policy ID # _____ Group # _____

Policy Holder Name _____ Date of Birth _____

Relationship to patient _____

Emergency Contact

Name _____ Phone Number _____

Relationship to patient _____

HIPAA DOCUMENTATION

Please answer all of the questions below and then sign and date. Thank you.

I acknowledge that I have been given the opportunity to read and/or receive a copy of Syracuse Pediatrics' Privacy Notice. **Yes** **No**

Is anyone else authorized to bring your child in for medical care? If so, please list their name, relationship & phone #.

_____

_____

Is anyone else authorized to discuss your child's care with us? If so, please list their name, relationship & phone #.

_____

_____

May we leave appointment messages or other medical information on :

Answering machine	Yes	No
Office voice mail	Yes	No
With persons listed above.	Yes	No

I certify that the above information is correct and true to the best of my knowledge. I understand that failure to provide any missing information may result in my being responsible for payment of services rendered to my child.

Date:_____ Signature:_____

I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Date:_____ Signature:_____

I authorize payment of medical benefits to above stated physician or supplier for services rendered.

Date:_____ Signature:_____